



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NATIONAL HOME HEALTH CARE
3615 SW 45TH AVENUE
AMARILLO TEXAS 79109

Respondent Name

AMERICAN ZURICH INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-09-4742-01

MFDR Date Received

January 5, 2009

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary taken from the table of disputed services: "We submitted the charges 3 times & made several calls, before we received a response. On 11/18/08 I spoke to Patricia @ Gallagher. She said it was denied to document error. And [sic] referred me to Janix 972-385-8852. I spoke to Nelda Oakley. She said it denied to billing on the wrong form. We need to bill on a UB04. I explained this is DME. She said it was an error and would send back to processing. The denial I just received just says no additional reimbursement allowed. Please process this claim. We billed on time, on the correct form, and with the correct documentation."

Amount in Dispute: \$122.95

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The service dates in July 22, 2008 and CPT is A6536 for Jobst Stockings. The billed amount was \$122.95. Requestor has included only the EOBs from the reconsideration review. The initial EOBs have not been submitted. Accordingly, the full nature of the dispute is unclear. Carrie will supplement its response once additional documentation is available. At present Carrier will maintain that it has made appropriate reimbursements for the services and its denial as shown on the EOBs was correct under applicable provisions."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
July 22, 2008	A6536	\$122.95	\$64.57

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203, sets out the fee guidelines for professional medical services provided

in the Texas workers' compensation system.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated December 23, 2008

- W4 – No additional reimbursement allowed after review of appeal/reconsideration.

Issues

1. Did the insurance carrier submit the missing EOBs along with the DWC060 response?
2. Did the insurance carrier issue payment for HCPCS code A6536?
3. Did the requestor submit documentation to support the billing of A6536?
4. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §133.307 “(d) Responses. Carrier or provider responses to a request for MDR shall be legible and submitted in the form and manner prescribed by the Division. (1) Timeliness. The response will be deemed timely if received by the Division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information. (2) Carrier Response. Upon receipt of the request, the carrier shall complete the required sections of the request form and provide any missing information not provided by the requestor and known to the carrier. (A) The response to the request shall include the completed request form and: (i) all initial and reconsideration EOBs related to the health care in dispute not submitted by the requestor or a statement certifying that the carrier did not receive the provider's disputed billing prior to the dispute request .”
 - Review of the insurance carrier's response did not include copies of missing EOBs.
 - EOB submitted by the requestor indicates “No additional reimbursement allowed after review of appeal/reconsideration.”
 - Review of the table of disputed services indicates that \$0.00 was paid for HCPCS code A6536.
 - Review of the EOB indicates \$0.00 payment was made for HCPCS code A6536.
 - Dispute resolution will therefore review the disputed charges according to the applicable fee guidelines.
2. Per 28 Texas Administrative Code §134.203 “(d) The MAR for Healthcare Common Procedure Coding System (HCPCS) Level II codes A, E, J, K, and L shall be determined as follows: 1) 125 percent of the fee listed for the code in the Medicare Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) fee schedule; (2) if the code has no published Medicare rate, 125 percent of the published Texas Medicaid fee schedule, durable medical equipment (DME)/medical supplies, for HCPCS; or...”
 - The insurance carrier issued \$0.00 for HCPCS code A6536.
 - The requestor billed HCPCS code A6536-NU
 - The –NU modifier identifies the purchase of new equipment
 - The requestor submitted a copy of the script for the Job Stockings, which supports the billing of HCPCS code A6536.
 - CGS Medicare does not have an assigned value for HCPCS code A6536.
 - Texas Medicaid Fee Schedule has an assigned value of \$51.66.
 - The Texas workers compensation fee guideline amount is calculated as follows: $\$51.66 \times 125\% = \text{MAR } \64.57 . This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$64.57.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$64.57 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	March 19, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.